



**THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
239 CAUSEWAY STREET, SUITE 200
BOSTON, MA 02114
617-973-0806
www.mass.gov/dph/boards**

BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS

**CHANGE OF
WORK SETTING INFORMATION**

Complete this form and submit it to the Board within 30 days of any change in your work setting. Complete a separate copy of this form for any additional changes in work setting in which you are employed as a physician assistant.

Physician Assistant:

LAST FIRST MIDDLE License Number

Address: _____

Effective Date: _____

Name of Facility or Office: _____

Address: _____

Type Facility: Office () Clinic () HMO () Hospital () Other: _____

Type Employment: Full time () Part time ()

List names of Massachusetts' hospitals at which you will practice or be affiliated with in this work setting:

Check all areas of practice that apply to this setting:

<input type="checkbox"/> Primary Care	<input type="checkbox"/> Administration	<input type="checkbox"/> Emergency Medicine
<input type="checkbox"/> General Surgery	<input type="checkbox"/> Internal medicine	<input type="checkbox"/> Occupational health
<input type="checkbox"/> Geriatric medicine	<input type="checkbox"/> Education	<input type="checkbox"/> Clinical research
<input type="checkbox"/> Obstetrics/Gyn.	<input type="checkbox"/> Pediatrics/Adolescents	
<input type="checkbox"/> Other (specify) _____		

Send this form within 30 days of any change in your work setting to: MA Board of Registration of Physician Assistants, 239 Causeway Street, Suite 200, Boston, MA 02114.